GOVERNMENT OF THE DISTRICT OF COLUMBIA

CRFMR
Rev. 9/02

DEPARTMENT OF HEALTH
HEALTH REGULATION & LICENSING ADMINISTRATION

Mailing Address
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Washington DC 20002
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Name of Facility:	Street Address, City, State, ZIP Code:	Survey Date:
Joye Assistant Living ALR -0027	6417 Kansas Avenue, NE Washington, DC 20017	08/26/19-08/27/19 Follow-up Dates(s):

Regulation Citation	Statement of Deficiencies	Ref. No.	Plan of Correction	Completion Date
	An annual survey was conducted on 08/26/19 through 08/27/19, to determine compliance with the Assisted Living Law (DC Official Code § 44-101.01 et seq) and the Assisted Living Residence (ALR) emergency and proposed regulations. The ALR provided care for seven residents and employed seven personnel to include professional and administrative staff. In addition, three Home Health Aides (HHAs) from two Home Care Agencies (HCAs) were providing services in the ALR. A random sample of three resident records and three employee records were selected for review. The findings of the survey were based on observation throughout the facility, clinical and administrative record review, review of the emergency preparedness program and resident and staff interviews. Listed below are abbreviations used throughout the body of this report: ALA – Assisted Living Administrator			

Name of Inspector — Date Issued: 09/10/19

Facility Director/Designee — Date: 09/26/2019

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ALR –Assistant Living Residence
EP – Emergency Plan
EPP – Emergency Preparedness Plan
HCA – Home Care Agency
HHA – Home Health Aide
HM – House Manager

10110.01	**The ALR shall develop and implement written policies on all of the following, which shall meet the requirements set forth by the Department:** **(k) Emergency preparedness, which shall meet the same standards for emergency preparedness as those set for long term care facilities by the Centers for Medicare and Medicaid Services, at 42 CFR &483.73;** This regulation is not met, as evidenced by:		
a.	**1. The ALR failed to ensure individualized strategies, adaptive equipment and staffing needs were incorporated into the EPP, as a strategy used to evacuate the most vulnerable residents during an emergency, for seven of seven residents in the ALR (Residents #1, 2, 3, 4, 5, 6 and 7).** On 08/26/19 at 9:32 AM, morning observations showed Resident #1 walking with an unsteady gait and unusual body movements. Resident #3 was observed walking slowly around the ALR using a cane.	10110.01 (a)	IN COMPLIANCE WITH 42 CFR SECTION 483.73 THE EPP RESPONSE TEAM MET POST SURVEY TO INCLUDE INDIVIDUALIZED STRATEGIES, ADAPTIVE EQUIPMENT AND STAFFING NEEDS INTO THE EVACUATION POLICY AND PROCEDURES. ALL SEVEN RESIDENTS WERE ASSESSED BY THE ALR RN INDIVIDUALIZED STRATEGIES FOR EVACUATION WAS IMPLEMENTED. ALL ALR RESIDENTS INCLUDING PROSPECTIVE SHALL HAVE INDIVIDUALIZED PLANS FOR EVACUATION 09/18/19 AND ONGOING

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At 10:48 AM, the ALA said during an interview that Resident #1 would be the most difficult to evacuate during an emergency due to the severity of the resident's overall health. The ALA stated that Resident #1 had one-to-one services during the morning shift to assist with her medical needs. When asked, the ALA said that some residents had adaptive equipment and required some type of assistance to evacuate during an emergency.

On 08/27/19 beginning at 10:38 AM, review of the ALR's EPP, dated 05/27/19, showed that no individualized strategies, adaptive equipment and staffing needs have been incorporated into the EPP to address the needs of Residents #1, 2, 3, 4, 5, 6 and 7.

During a follow-up interview at 10:33 AM with the ALA, she confirmed that she needed to develop and incorporate individualized plans to assist with evacuating during an emergency for Residents #1, 2, 3, 4, 5, 6 and 7, to include staffing needs and equipment.

At the time of the survey, the ALR failed to ensure that the EPP included individualized strategies, adaptive equipment, and staffing supports to ensure residents health and safety during and after an emergency evacuation.

2. The ALR failed to identify which staff would assume the leadership role during an emergency, for seven of seven residents in the ALR (Residents #1, 2, 3, 4, 5, 6 and 7).

ALL ALR STAFF RECEIVED AN INSTRUCTION ON THE ADDED SECTION OF THE EVACUATION. ALA SHALL ENSURE THAT ALL PROSPECTIVE EMPLOYEES AND THIRD PARTY EMPLOYEES SHALL RECEIVE TRAINING ON THE FACILITY'S EPP WITHIN 7 DAYS OF EMPLOYMENT OR ASSIGNMENT TO THE FACILITY.
JOYE ASSISTED LIVING SHALL TRAIN ALL FACILITY AND THIRD PARTY STAFF ANNUALLY ON INDIVIDUALIZED PLAN FOR THE RESIDENTS.
ALL RESIDENTS RECORDS SHALL BE REVIEWED QUATERLY TO ENSURE THAT EACH RESIDENT HAS AN EMERGENCY ASSESSMENT IF NEED PERFORMED.

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	On 08/27/19 beginning at 10:38 AM, review of the ALR's EPP, dated 05/27/19, showed no documented evidence for which staff per shift would be responsible for the leadership role during an emergency. At 10:35 AM, an interview was conducted with the ALA regarding staff assuming specific leadership roles during an emergency. The ALA was able to verbally tell the surveyor the roles each staff would play during an emergency. When asked, the ALA stated that there was no written authorized staff member responsible on each shift to assume the leadership role during an emergency in the EPP. At the time of the survey, the ALA failed to ensure that the EPP identified which staff member would assume the leadership role if the ALA, HMs and maintenance could not be reached during an emergency.	10110.01 (b)	THE ASSISTED LIVING SERVICES EPP WAS UPDATED POST SURVEY TO INCLUDE THE ROLES OF EACH STAFF AND NAME AND SUBSTITUTE STAFF IN THE EPP. ALL ALR STAFF RECEIVED INSTRUCTIONS AND A HANDOUT WITH THE NAMES, TELEPHONE NUMBERS OF THE ~~SPECIFIC~~ EMERGENCY RESPONSE TEAM AND THE SPECIFIC ROLE THAT EACH STAFF PLAYS DURING AN EMERGENCY. ALL STAFF AND THIRD PARTY STAFF SHALL RECEIVE TRAINING ANNUALLY. STAFF AND THIRD PARTY EMPLOYEES RECORDS SHALL BE REVIEWED QUATERLY TO ENSURE STAFF RECEIVED TRAINING ON THE ~~FACILITY'S~~ EPP	09/18/19 AND ONGOING
b.	**The ALR failed to show documentation of efforts relevant to the process for ensuring cooperation and collaboration with local, regional, state and federal emergency preparedness officials' efforts to ensure an integrated response during a disaster or emergency situation, for seven of seven residents residing in the ALR (Residents #1, 2, 3, 4, 5, 6 and 7).** On 08/27/19 beginning at 10:38 AM, review of the ALR's EPP, dated 05/27/19, showed no evidence that the ALR collaborated with local, regional, state and federal EP officials to ensure an integrated response during a disaster or emergency situation.	10110.01 (b)	THE ASSISTED LIVING SERVICES EP DESIGNATED PERSONNEL WAS GIVEN THE TASK OF ENSURING COLLABORATION WITH LOCAL AND FEDERAL EP OFFICIES IS ACCOMPLISHED DURING A DISASTER. DESIGNATED EP RESPONSE PERSONNEL REACHED OUT TO THE LOCAL FIRE DEPARTMENT	

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c.

At 10:52 AM, the ALA confirmed during an interview that she had not reached out to any state or federal officials regarding emergency planning.

At the time of the survey, there was no evidence that the facility documented efforts to reach out to local, regional, state and federal EP officials for collaborative and cooperative planning efforts to ensure an integrated response during a disaster and/or emergency.

The ALR failed to develop written policies and procedures to ensure adequate alternate energy sources necessary to maintain temperatures during emergency situations, for seven of seven residents residing in the facility (Residents #1, 2, 3, 4, 5, 6 and 7).

On 08/27/19 beginning at 10:38 AM, review of the ALR's EPP, dated 05/27/19, showed no evidence that policies and procedures had been developed to ensure adequate alternate energy sources necessary to maintain hot and cold temperatures for residents to shelter in place; and when to evacuate residents if temperatures within the ALR could not be maintained.

At 10:48 AM, the ALA said during an interview she had not developed policies and procedures specifically to address maintaining temperatures should the residents have to shelter in place. The ALA did state that there were adequate blankets and extra clothing in the ALR for the residents. The ALA further stated that if the temperature became too hot or cold,

10111.01 (C)

REPRESENTATIVE OF THE COMMUNITY CENTER ACROSS THE STREET FROM THE FACILITY, LOCAL WITH DISTRICT POLICE DEPT. EP RESPONSE TEAM PERSONNEL WILL OUT CONTINUE TO REACH EP WITH LOCAL, FEDERAL OFFICIALS 09/18/19 AND ONGOING

THE EPP RESPONSE TEAM FOR THE FACILITY MET POST SURVEY TO PLAN AND IMPLEMENT POLICIES AND PROCEDURES OF ALTERNATE ENERGY SOURCES THAT WILL ALLOW THE RESIDENTS AND STAFF TO SHELTER IN PLACE DURING EMERGENCY SITUATIONS AND WHEN TO EVACUATE THE RESIDENTS AND STAFF IF THE TEMPERATURE WITHIN THE FACILITY CANNOT BE MAINTAINED. ALL STAFF RECEIVED TRAINING ON MAINTENANCE OF TEMPERATURE IN THE FACILITY DURING AN EMERGENCY SITUATION AND THE EVACUATION PROCESS WHEN TEMPERATURE IN THE FACILITY CANNOT BE MAINTAINED. COPY OF THE EVACUATION PROCEDURE WAS GIVEN TO ALL STAFF. STAFF WERE ALSO INSTRUCTED ON THE LOCATION OF ALL SUPPLIES. 09/18/19 AND ONGOING

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the residents would evacuate to a hotel.

At the time of the survey, there was no evidence that the facility developed policies and procedures which identified the ALR's temperatures for sheltering in place in order to protect the residents health and safety.

d. **The ALR failed to develop policies and procedures that addressed a system that protects the confidentiality of resident information during an emergency, for seven of seven residents residing in the ALR (Residents #1, 2, 3, 4, 5, 6 and 7).**

On 08/27/19, beginning at 10:38 AM, review of the ALR's EPP, dated 05/27/19, showed no evidence that policies and procedures had been developed that outlined medical records systems to preserve the residents information, to protect confidentiality of residents information, and to secure and maintain the availability of records during an emergency.

At 11:27 AM, the ALA said during an interview that there were no policies and procedures that outlined medical records system that preserved residents' information. The ALA said that the policies and procedures would have to be developed and added to the EPP.

At the time of the survey, there was no evidence that the ALR developed policies and procedures that addressed ensuring the confidentiality of residents' information.

e. **The ALR failed to develop policies and procedures that**

SEE EPP EVACUATION PROCESS ~~AN~~ ON TEMPERATURE MAINTENANCE.

POLICIES AND PROCEDURES WERE DEVELOPED POST SURVEY, THAT OUTLINED PRESERVATION OF RESIDENTS INFORMATION MAINTAINING CONFIDENTIALTY OF RESIDENTS INFORMATION AND AVAILABILITY OF RECORDS DURING AN EMERGENCY. A SHORT FORM -EPP MEDICAL ~~FORM~~ WAS CREATED ~~FOR~~ ALL RESIDENTS CONTAINING MEDICAL INFORMATION, PRIMARY MD, DIAGNOSES, MEDICATIONS- NAME, DOSAGE, FREQUENCY ROUTE and ALLERGIES, EMERGENCY CONTACT PERSON: NAME/PHONE NUMBER. A COPY OF THE SHORT FORM WAS PLACED IN EACH RESIDENTS PERMANENT FOLDER AND A COPY WAS PLACED IN A FOLDER IN THE LOCKED EPP EVACUATION BRIEF CASE. ALL FACILITY STAFF RECEIVED INSTRUCTION ON THE POLICIES AND PROCEDURES

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addressed the use of volunteers during an emergency, for seven of seven residents residing in the ALR (Residents #1, 2, 3, 4, 5, 6 and 7).

On 08/26/19 beginning at 10:38 AM, the ALA (EP leader) said during the initial interview that the ALR would not use volunteers during an emergency situation.

On 08/27/19 at 11:30 AM, review of the ALR's EPP, dated 05/27/19, showed no evidence that policies and procedures had been developed to address how and if the ALR would use volunteers during emergencies.

At 11:30 AM, the ALA stated that she did not put in place policies and procedures related to the use of volunteers during emergency situations because she knew that she was not going to use them.

At the time of the survey, there was no evidence that the ALR's EPP addressed the use of volunteers during emergencies.

f.

The ALR failed to develop policies and procedures that described its role in providing care during major disasters or federal emergencies in alternate care sites, for seven of seven residents residing in the ALR (Residents #1, 2, 3, 4, 5, 6 and 7).

On 08/27/19 beginning at 10:38 AM, review of the ALR's EPP, dated 05/27/19, failed to show evidence that the ALR had developed policies and procedures to address the role of

10/10/19

AND THE LOCATION OF THE EPP MEDICAL INFORMATION BRIEF CASE. ANNUAL IN-SERVICE SHALL BE GIVEN ANNUALLY ON THE FACILITY EPP. EPP RESPONSE TEAM SHALL MEET ANNUALLY TO UPDATE THE FACILITY'S EPP.
SEE EPP - CONFIDENTIALITY OF MEDICAL RECORDS

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POST SURVEY, THE ALA REACHED OUT TO NEIGHBORS AROUND THE FACILITY TO ADDRESS AND ASK IF THEY WOULD BE WILLING TO ASSIST AS VOLUNTEERS DURING AN EMERGENCY SITUATION THE ADDRESS OF THE NEIGHBORS WILLING TO ASSIST WERE ADDED TO THE POLICIES AND PROCEDURES OF THE USE OF VOLUNTEERS DURING AN EMERGENCY SITUATION
SEE EPP POLICIES AND PROCEDURES ON USE OF VOLUNTEERS.
ALL FACILITY STAFF RECEIVED INSTRUCTION ON THE USE OF VOLUNTEERS DURING AN EMERGENCY SITUATION. STAFF SHALL RECEIVE AN INSERVICE ANNUALLY AND WHEN AN UPDATE OR CHANGE IS MADE TO ANY OF THE POLICIES AND PROCEDURES OF THE EPP.

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	the ALR under a waiver declared by the Secretary of Health and Human Services (public health emergencies) or in the provision of care and treatment at an alternate care site identified by emergency management officials when the President of the United States, in accordance with section 1135 of the Stafford Act, declares a major disaster or emergency. At 11:32 AM, the ALA (EP leader) said during an interview that there was no policy and procedure in place regarding the 1135 waiver. The ALA stated that she needed to develop and incorporate a policy and procedure into the EPP regarding the 1135 waiver. At the time of the survey, there was no evidence that the facility's EPP addressed the provision of care at alternate sites during declared national emergencies.		A POLICY AND PROCEDURE WAS DEVELOPED POST SURVEY TO ADDRESS THE EP 1135 WAIVER WHICH ADDRESSED THE PROVISION OF CARE AND TREATMENT AT AN ALTERNATE CARE SITE DURING AN EMERGENCY SITUATION. ALL STAFF RECEIVED INSTRUCTIONS ON THE 1135 WAIVER. THE FACILITY'S EPP RESPONSE TEAM SHALL MEET ANNUALLY TO DISCUSS AND UPDATE ALL AREAS OF THE EPP.	09/20/2019 AND ONGOING
g.	**The ALR failed to show evidence that it trained all staff on initial emergency preparedness training, for 3 of 3 agency staff employed by the ALR (HHAs #2, 7 and 8).** On 08/27/19 at 10:07 AM, HHA #2 was asked about the facility's EPP and tracking system during an emergency. HHA #2 said that she had received training on EP from the HCA, but not from the ALR. HHA #2 stated that she was not familiar with the tracking system here. The ALA, who overheard the interview, stated that none of the three HCA staff had been trained on the EP. The ALA stated that she will train the agency staff as soon as possible.	10110.101(g)	ALA COULD NOT COMPLETE TRAINING OF HHAs #2, 7, and 8 ON THE FACILITY'S EPP AND TRACKING SYSTEM DUE TO THE FACT THAT DHCF NOTIFIED THE ALA THAT THE FACILITY COULD NOT UTILIZE HHAs IN THE FACILITY FACILITY AS OUTLINED IN DCMR SECTION 4216.7 HHAs #2, 7, 8 STOPPED PROVIDING SERVICES TO THE RESIDENTS IN THE FACILITY EFFECTIVE 09/11/2019. THE FACILITY UPDATED THE EPP ON TRAINING THIRD PARTY PROVIDER WITHIN 14 DAYS OF THE	09/11/19 AND ONGOING

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	At 11:48 AM, review of the EP in-service training documents showed no evidence that the ALR had trained HHAs #2, 7 and 8 on the EPP. At the time of the survey, there was no documented evidence that agency staff received initial training on the ALR's EPP.			
10110.01	**(n) Supervision of independent contractors performing work on the ALR's internal and external premises:** **The ALR did not develop written policies to provide for the supervision of independent contractors working on the internal and external premises for the safety of seven of seven residents residing in the facility (Resident #1, 2, 3, 4, 5, 6, and 7).** During an interview on 08/27/19 at 1:20 PM, the ALA said that the ALR in the past had utilized independent contractors to paint the interior of the ALR and to perform lawn care. However, the ALA acknowledged that the ALR had not developed any written policies to provide for the supervision of independent contractors that provided services in the ALR. Further interview indicated that the ALA would develop and implement written policies to provide supervision for all independent contractors providing services at the ALR. At the time of the survey, the ALR failed to develop written policies to provide for the supervision of independent contractors performing work at the ALR.	10110.01 (1)	POLICIES AND PROCEDURES ON THE SUPERVISION ~~OF~~ OF INDEPENDENT CONTRACTORS PERFORMING WORK ON THE ALR'S INTERNAL AND EXTERNAL PREMISES WERE DEVELOPED POST SURVEY. ALR ALA SHALL REVIEW ALL NEW RULES AND REGULATIONS QUARTERLY AND SHALL UPDATE ALL POLICIES AND PROCEDURES TO MEET REQUIREMENTS OF ANY NEW RULES AND REGULATIONS	09/12/2019 AND ONGOING

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0027	A. BUILDING: _____ B. WING _____	08/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYE ASSISTED LIVING SERVICES	6417 KANSAS AVE NE WASHINGTON, DC 20017

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	Initial Comments An annual survey was conducted on 08/26/19 through 08/27/19, to determine compliance with the Assisted Living Law (DC Official Code § 44-101.01 et seq) and the Assisted Living Residence (ALR) emergency and proposed regulations. The ALR provided care for seven residents and employed seven personnel to include professional and administrative staff. In addition, three Home Health Aides (HHAs) from two Home Care Agencies (HCAs) were providing services in the ALR. A random sample of three resident records and three employee records were selected for review. The findings of the survey were based on observation throughout the facility, clinical and administrative record review, review of the emergency preparedness program and resident and staff interviews. The survey findings determined that the ALR was in substantial compliance with DC Code 44-101.01; however, deficient practices were identified related to the emergency and proposed regulations.	R 000		